

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009192

DO NOT WRITE
ON THIS STUB

AMENDED

FILED FEB 19 1963

318

Primary Registration District No.

1003

Registrar's No.

1346

STATE FILE NUMBER

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4823 Rhodes Ave.		d. STREET ADDRESS (If outside, give location) 4823 Rhodes Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last MARIE J. PETERSEN		4. DATE OF DEATH Month Day Year Feb. 5 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-21-1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11a. FATHER'S NAME Carl J. Petersen		11b. MOTHER'S MAIDEN NAME Lillie E. Cennater	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		17. INFORMANT Lillie E. Petersen 4823 Rhodes Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial collapse + auricular fibrillation DUE TO (b) Chronic Rheumatic heart disease DUE TO (c) acute urinary failure.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. 416X <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 2/14/62 to 2/5/63 and last saw her alive on 2/5/63 Death occurred at 2:10 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. J. A. Dowd M.D.		22b. ADDRESS 2919 S. Kingshighway	
22c. DATE SIGNED 2/6/63		22d. LOCATION (City, town, or county) St. Louis, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 8, 1963	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery	
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.		25. DATE RECD. BY LOCAL REG. FEB 7 1963	
26. REGISTRAR'S SIGNATURE Paul Smith, M.D.			

USE BLACK INK

OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

James R. Arman

Licensed Embalmer No. 4527

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.